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TRIP REPORT NO. 887

KYRGYZSTAN UPDATE: LICENSING & ACCREDITATION, CLINICAL INFORMATION SYSTEMS AND FAMILY GROUP PRACTICE

June 1-21, 1997
Bishkek and Karakol, Kyrgyzstan

Prepared under Task Order 551 by:
George P. Purvis, MBA, FACHE

Submitted by the Zdrav*Reform* Program to:
AID/ENI/HR/HP

AID Contract No. CCN-0004-C-00-4023-00
Managed by Abt Associates Inc.
with offices in: Bethesda, Maryland, U.S.A.
Moscow, Russia; Almaty, Kazakstan; Kiev, Ukraine
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I. EXECUTIVE SUMMARY

The health system of the Kyrgyzstan is in the process of undergoing a major transition from the traditional Soviet model, dominated by medical specialists, to a primary care oriented family medicine delivery system. A Mandatory Health Insurance Fund (MHIF), with a capitated rate to cover the family practitioner population, and a per case payment system for hospitals is being established. This rapidly changing system is in need of an effective health facility licensing and accreditation (L&A) process, and an effective Family Group Practice (FGP) network including a highly developed Clinical Information System (CIS).

The objectives of this second consulting trip to Kyrgyzstan were: 1) to assist counterparts with the development of an effective L&A process and 2) to continue to assist counterparts with the design, development, and institutionalization of the CIS which includes the accounting, financial, and management systems to support the MHIF and its major components (hospitals, polyclinics, and (FGPs), and 3) continued development of the FGPs.

The results of these consulting activities were as follows:

- Conducted an education and training program/workshop for counterparts in the L&A and FGP components of the project. Additional work on L&A standards is needed to adapt them further to Kyrgyzstan, and additional training of technical L&A surveyors and health care facility personnel would be beneficial. Long-term monitoring of the L&A process is needed to ensure correct implementation.

- Reviewed the existing CIS and recommended improvements in the design, development, and installation of the various inputs and outputs. The new CIS form needs to be tested and evaluated; then FGP personnel—especially physicians—should be trained to use it correctly. Long-term management of the information collection, tabulation and analysis should be a high priority.

- Reviewed the activities in the Karakol Intensive Demonstration Site and listed findings and recommendations. Reducing self-referrals to specialists and developing new software for CIS analysis (as well as the aforementioned improvements in information collection and analysis) should be priorities. FGP practice managers are a valuable asset but more supervision of them is recommended. Rationalization of inpatient facilities has made little progress in the past two years; this process needs to be implemented.

II. BACKGROUND

This trip report is a review of the Zdrav*Reform* work which this consultant performed during the period June 1-21, 1997 in conjunction and coordination with the World Bank Project in Health Reform. This was the consultant's second major visit to the city of Bishkek, Kyrgyzstan. The focus of this trip was the continuing design, development, and implementation of licensing and accreditation (L&A) process for all of Kyrgyzstan as a follow up to the work done in the Issyk-kul Oblast Intensive Demonstration Site (IDS), Kyrgyzstan. A number of previous reports on the

overall developmental needs of the health system in Kyrgyzstan were produced during 1994-97 and are listed in the bibliography of this report. The major objective for this consultant's visit was to assist with and continue the institutionalization process of L&A and to provide recommendations for the improvement in the Family Group Practice (FGP) development including an effective Clinical/Management Information System (CIS/MIS).

III. OBJECTIVES:

The SOW, major objectives, tasks and outputs for this consultant were as follows:

- Finalize the beginning design, development, and implementation of the L&A and FGP processes for Kyrgyzstan;
- Review and recommend improvements to the CIS/MIS
- Conduct training and workshops for FGPs as necessary and for the other counterparts on various issues and programs.

IV. FINDINGS AND RECOMMENDATIONS

A. Licensing and Accreditation Update

1. Background and Update

The process of establishing an L&A Program for Kyrgyzstan began in October 1995 with a series of seminars on the process of hospital licensing and accreditation conducted by Zdrav*Reform* and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) in Bishkek and Karakol (see Bibliography). The seminars reviewed the various L&A processes and some 500 individual standards used by the JCAHO in accreditation of hospitals in North America.

These seminars were followed up in the Karakol IDS with a consultancy in February 1996 by this consultant, which made the North American document more country- and facility-specific and factored in the uniqueness of the countries of the Consortium of Indepenedent States and the structure and organization of hospitals in the former Soviet Union. This resulted in the elimination of some of the non-relevant sections (Board of Trustees, Patient Rights, Finance, and others) and reduced the 528 individual standards to 307 individual standards which would better fit the environment and the existing resource needs.

Additional efforts during 1996 were delayed due to other issues and priorities. With the initiation of the World Bank Health Reform Project and the extension of Zdrav*Reform,* new funds became available to continue the work on the L&A component of the Program.

2. Update on Activities

With the World Bank Project on Health Reform, funds were made available to hire personnel to work on L&A development for hospitals in Kyrgyzstan. Exhibits 1 and 2 in the Appendix present

the decree and outline the organization chart and positions which are available to work on the L&A component of the project. Considerable effort has gone into the selection and hiring of staff, and plans are underway to begin the education and training of a group of experts to begin the process of surveys and actual accreditation of hospitals. The consultant was requested to work with this new group to follow up on the work done in Karakol and to assist them in developing plans for full implementation country wide of an effective and efficient L&A program.

The consultant met with the chairman of the Kyrgyzstan Licensing and Accreditation Commission and the group of L&A technical experts on a number of occasions, and he conducted workshops and training programs for this group on L&A policies, procedures, practices, and methodology. (See Exhibit 3 in the Appendix for workshop topics and agenda.) In addition to the workshop, the consultant did a considerable amount of role playing with the group of experts on the how-to process of carrying out a survey, which included a mock survey of one institution.

3. Follow-up Activities

While the L&A Commission has developed its own list of activities and priorities, and the consultant was not asked specifically to develop a list of follow-up activities, the following is provided for reference purposes only.

a. Short-term Activities

i. The L&A Commission will need to re-review and refine the materials presented in the workshop to make the standards more specific to the Kyrgyzstan environment. This means reviewing each standard and rewriting it to fit the health facilities organization and management structure in Kyrgyzstan. The standards as presented in the JCAHO workbook are specific to North American hospitals and are not relevant to most CIS operating facilities.

ii. The Commission will need to be extremely careful in the process of conducting licensing standards and should not allow the standards to be too rigid or too complex in the beginning. Considering the resource constraints in the environment and the difficulty in enforcing closure procedures, more realistic and practical standards should be used.

iii. An Advisory Committee of Hospital Chiefs is needed by the Commission to review and work with the expert group to ensure that standards are fair and practical.

iv. The Commission will need to conduct a variety of seminars and educational and training programs for hospital chiefs and other key health facilities staff to acquaint them with the standards and the process of both licensing and accreditation. This should be a major effort and will need to be conducted in a number of phases, beginning with the first group of hospitals to be licensed and accredited.

v. The Commission will need to conduct extensive training and education of the group of technical experts chosen to conduct the L&A process and procedures. This should include training both in-country and outside of the country, including visits to other countries of the Consortium of

Independent States, Europe and North America. Some training in a hospital setting for the surveyors would be preferable to just classroom training.

2. Long-term Activities

i. The L&A Commission, the Ministry of Health (MOH), the Mandatory Health Insurance Fund (MHIF) and other interested parties will need to closely monitor the L&A process to see if it is meeting the original objectives as outlined in the World Bank Agreement. This means a careful review of licensing as opposed to accreditation and determining the changing needs of the health facilities in a rapidly changing economic and political environment.

ii. The Commission and the MHIF will need to closely monitor the behavior of the L&A reviewers (inspectors or surveyors) to ensure that personnel with the right positive, helpful, and educational attitudes and behavior are being utilized and that personnel with negative, punitive, and non-educational behavior are removed from the accreditation process.

iii. The MOH and MHIF will need to continually monitor the L&A process to measure both the costs and benefits of the programs. At the four-year decision point of splitting the licensing from the accreditation process, some idea of both the costs and benefits of each of the two functions will need to be available.

iv. A long-term advisory group of providers (hospitals, polyclinics, FGPs) will be needed to assist the L&A Commission develop, refine, and improve standards of both licensing and accreditation over time.

B. Clinical Information System Development

1. Background

The design, development, and implementation of effective Management and Clinical Information Systems (MIS/CIS) has been a priority of the Zdrav*Reform* Program. This consultant first began work on this component of the project in May 1995 (see Bibliography). The MIS began with the development of the FGPs and the need for an effective management, accounting, and financial system. This MIS/CIS was later expanded to include the needs of the newly emerging Kassa, the need for a CIS database for project evaluation, the need for computerization needs, the needs of the MOH for specific information and data, and, later, the need for education and training.

The original CIS form was developed to meet the needs of the FGPs but was expanded to take on a variety of other needs. With the expansion came new problems and opportunities. Problem areas included data collection and computerization. This was remedied by the introduction in FGPs of practice managers (PM), who duties include assistance with the collection, interpretation, and utilization of data. Over the last two years considerable time and effort has gone into the creation of this database. An excellent discussion of the issues and problems as well as opportunities is outlined in the paper by Tokon Ismailova, *Key Aspects of Data Collection in Health Care Reform: Observations from Issyk-kul, May 1997*.

With the rollout of the Karakol demonstration to all of Kyrgyzstan, and with the assistance of the World Bank Project, a new opportunity arose to look again at the database and to implement a more effective and efficient system of tabulation, collection, reporting, and utilization of this data. The consultant spent considerable time with counterparts reviewing existing problems and opportunities of the new CIS. A decision was taken to utilize the newer version of the form which meets a number of needs (clinical, financial, management, MHIF, MOH, data systems and evaluation).

2. Update: Findings and Recommendations

A review of the existing problems with the old Karakol database/CIS showed that the forms were not being filled out correctly nor was the data being inputted or utilized effectively. The failure to educate and train Karakol physicians on the importance of the form, as well as the failure to follow up with physicians to correct deficiencies in procedural methods, resulted in large quantities of forms which were unusable for data input or evaluation purposes. As the Karakol IDS was an experiment, and much has been learned, it is now necessary to roll out the successes to all of Kyrgyzstan, and to limit the failures. Meetings were held with the STLI group and the FGP Association (FGPA) as well as the MOH to discuss the needs and recommendations for the introduction of the CIS/MIS in Kyrgyzstan. A decision was taken to use the newly designed form which requires accurate write in information by physicians but is more promising in that it meets the needs of a wider group of sources.

3. Follow-up Activities

In order to successfully implement the CIS/MIS in the FGP environment in Bishkek and Chui, the following steps will need to be carried out:

a. Short-term

i. The Information Systems (IS) professionals who work with the FGPA will need to set up a trial or test run for the new form. This test should be long enough to ensure sufficient collection of data, which will evaluate the new form, and may (depending on statistical needs) be a database for evaluation.

ii. With the assistance of the PMs and the FGPA, the IS professionals will need to educate and train the FGP physicians on the importance, the correct procedure, and the methods and utilization of the form. This training should begin with the FGPA and the PM's and then proceed to the physicians.

iii. Forms that are filled out incorrectly will need to have corrections made daily by the physicians themselves, in order to ensure corrective action and understanding of the proper way to fill out the forms.

iv. The forms will need to be key punched and go into a database program for analysis and evaluation.

v. A first effort to review and analyze the data to meet the needs of the various parties will need to be monitored closely to ensure the form and data analysis is appropriate to the needs of these groups.

vi. The present software for CIS data input/output needs to be revised, as the Karakol PMs find it too cumbersome to use efficiently. This should be a priority.

b. Long-term

i. The on-going management of proper filling-out of the forms and collection, tabulation, analysis and evaluation of the data from the forms will have to become a bigger priority. This was one of the failures of the Issyk-kul experiment and should not be allowed to recur.

ii. The on-going changes and improvements in the form will need to be made to ensure that the system improves over time. While this did occur in Karakol, it was not managed well and the FGPA needs to be involved in the approval and on-going management of the changes.

C. Family Group Practices in Karakol

1. Background

The development of Family Group Practices in Kyrgyzstan has been well documented (see Bibliography). The Karakol IDS and the Issyk-kul experiment has been under development and implementation since 1995. Considerable effort and resources including training, instruments, equipment, management, renovations and facilities have been focused into the development of effective FGPs in Karakol during the period 1995-97 and is on-going. The success of the Karakol experience is now being rolled out with the assistance of the World Bank to all of Kyrgyzstan. The consultant was requested to follow up on the activities of his five prior visits to Karakol, in order to update Program managers on the progress and problems of the present environment. This activity was planned to follow the departure of the IDS Manager Dean Millslagle, who left in mid-June. The consultant also spend considerable time in Bishkek working with the FGPA on mission, vision, and strategies.

2. Update

The move of many Karakol staff to the Bishkek project and the departure of the IDS manager has resulted in some confusion about roles and responsibilities. However, things are beginning to settle down and personnel are becoming comfortable with their new roles. Most of the activities and findings are presented in Zdrav*Reform* Trip Report 890 (Brad Else) and need not be repeated in this document. However, outlined in the next section is a list of recommendations for follow-up activities identified by this consultant as needing attention in the near future.

3. Recommendations for Follow-up Activities

The Karakol IDS Management will need to follow up on the items listed below:
a. The Marketing Group in Karakol is presently spending most of its efforts on Family Planning. This group should begin to made preliminary plans for the marketing and information dissemination of the upcoming changes in the MHIF and the Rationalization Program. There is also a major marketing effort needed in the area of reducing the self-referrals to hospitals and polyclinics specialists. This is a significant issue and needs effort and resources now. This should become a high priority for the marketing group.

b. The issue of self-referrals is a major problem and will need not only marketing assistance but some type of negative incentive, such as a user fee.

c. The development of new software for the MIS/CIS input/output analysis should also be a big priority. It is the consultant's understanding that this is in process, but it has been in-process for some 12 months and needs to be finalized. Some progress was made in Bishkek with the finalization of the form, and this may speed up the software.

d. Future procurements of medical instruments and equipment should ensure that quality items are purchased. Visits to the FGPs by this consultant have shown that much of the early procurement of instruments and equipment resulted in poor quality items which broke quickly and thus are unusable. This included stethoscopes and blood pressure instruments, and baby weighing scales.

e. Feedback and daily corrections to FGPs on the filling out of the "Purvis forms" MIS/CIS should be a high priority for PMs. A review of this by the consultant at a number of FGPs has shown that while things are improving they still have a long way to go.

f. A review of the progress of the PMs on the development of FGP business plans showed that there has been some action taken in this area. However, discussion with PMs and a review of some of the information has shown that there is still much to be done. This needs to get finalized in the very near future.

g. While the PMs have in general been a success, there is still much to be desired in their overall direction and supervision, especially in the rural areas. It is strongly recommended that a full-time supervisory position be created. The PMs need continual, full-time planning and control of their activities, time, and behavior. This should be a first-level priority.

D. Rationalization Update

The consultant reviewed the proposed rationalization plan which is to be sent to the Issyk-kul Oblast Health Department (OHD) and the Ministry of Finance (MOF). The plans are very similar to those submitted to the OHD some two years ago by this consultant. During the two-year period very little except reducing unused beds has been accomplished. The need to bring about serious, on-going, and realistic rationalization should be a high priority. The longer it is delayed the longer the pain will have to be endured by everyone. The recommendations to close the TB, STD, Psychiatric, and Oncology Dispensaries and to move the units into the general hospital are all very practical. The merging of the Pediatric and Maternity Hospitals and closure of the Pediatric

Polyclinic and Hospitals (both of which are in poor condition) should be a high priority and should be easy to do and would result immediately in better quality care for children. A review of some of the data, especially in rural areas, has shown that the practice of greatly inflating statistics on beds and visits continues to be the standard practice. This will mean that personnel involved in rationalization will have to go and visit facilities to determine what is real and what is false. It is better to go " look and see" before any decisions on closure of facility are taken.

VI. MONITORING AND EVALUATION

The process of monitoring normally involves a review of actual accomplishments against the original plans. Discussion centers around what went well and what did not, as well as why they did or did not go well, and, finally, making adjustments to future plans. Often, a report is written to outline the "lessons learned" which is shared with colleagues and other similar projects.

With respect to the consultant's Findings and Recommendations:

- Were the findings and recommendations reviewed in a timely manner with Almaty, Bethesda, the OHD, and USAID? A period of 6-8 weeks (August 15-30)would be considered timely. However, with translation delays, 8-10 weeks (September 15-30) may be more realistic.
- Were decisions taken in a timely manner with respect to the recommendation, and were any follow-up studies conducted to verify or develop further? A period of 3-4 months (through October 15 or November 15) would be reasonable.
- Were the findings and recommendation on the L&A process reviewed and acted upon in a timely manner? Was action taken?
- Were the items requested to be completed between trip 5 (June) and 6 (September) actually done ?

VII. DAILY TRIP ACTIVITIES:

Following is a day-by-day account of the consultant's activities.

June 1/2: Traveled from Philadelphia to Almaty and Bishkek via Frankfurt.
June 3: Met with Sheila O'Dougherty and Almaty office staff; traveled from Almaty to Bishkek and met with Bishkek staff to review plans and priorities.
June 4: Met with L&A Chairman Asanaly Saadakbayevich and key counterparts to review status of L&A plans and projects.
June 5: Met with Bishkek staff to review FGP development, hospital association development, and CIS/MIS development.
June 6: Met with key L&A counterparts to review ideas for workshop presentation and dry run for L&A hospital review. Met with FGP to recommend CIS form and methodology.
June 7: .Worked on a variety of project areas and traveled to Almaty.
June 8/9: Met with Almaty staff (Borowitz and O'Dougherty) and worked on a variety of project areas and began writing trip report.
June 10: Traveled to Bishkek from Almaty and met with Bishkek staff.
June 11/12: Worked with FGP, L&A, and CIS counterparts.
June 13: Worked with FGP and L&A counterparts and traveled to Karakol.
June 14/15: Met with Karakol staff and worked on various issues and programs.
June 16/17: Met with Karakol counterparts, visited FGPs and traveled to Bishkek.
June 18/19: Worked with L&A, HA, and FGP counterparts.
June 20: Worked on FGP and L&A activities and traveled from Bishkek to Almaty.
June 21: Travel from Almaty to Philadelphia via Frankfurt.

XIII. REFERENCES:

A. BIBLIOGRAPHY

Beck, Leif C., **The Physician's Office: A Guide to Planning and Managing a Successful Medical Practice,** Exerpta Medica, 1977.

Becker, G. and Bruce Ente, **Health Facility Licensing and Accreditation Administrative Policies and Procedures**, Krygyz Republic, Ministry of Health, July 1995.

Ismailova, Tokon, Key Aspects of Data Collection: Issyk-kul Observations, May 1997.

Langenbrunner, J., Financial Management Reforms, Kyrgyzstan, (March 1995)

Purvis, G. P., trip reports from prior Zdrav*Reform* consultancies (July 1995, October 1995, February 1996, May 1996) and course materials on Management of Health Services.

Pavlock, E.J., **Financial Management of Medical Groups,** Center for Research in Ambulatory Health Care Administration, copyright 1994.

B. PERSONS CONTACTED

Almaty Abt Office:

Michael Borowitz, MD, Regional Director
Sheila O'Dougherty, Deputy Director
Alcazar Chukmaitov, Interpreter
Marina Poltorakina, Office Manager
Yuri Lisitsen, MD, Quality Assurance and Clinical Specialist
Eugene Koutanov, MIS Specialists

Bishkek Abt Office:

Jack Oppenhuizen, Project Director
Dean Millslagle, Karakol IDS Manger
Naripa Mukanova, Project Coordinator
Indira Sadykbaeva, Office Manager

Bishkek Department of Health and Related Departments:

Ainagul Isakova, FGPA Administrator
Kubanychbek Djemuratov, Administrator for Bishkek Hospital Association
Alimjan Koshmuratov, Administrator for Chui Hospital Association
Asanaly Sadakbaevich Sadakbaev, Head L&A Commission
Beishekan Kalieva , Director, Republican Kassa
Acelle Sargaldakova, Coordinator for the Health Policy, Research, Evaluation

Other Organizations:

Dr. David Frick, Surgeon, STLI
Dr. Brad Garrish, Family Medicine, STLI

L&A Workshop Participants, June 1-13, 1997:

Asanaly Sadakbaevich Sadakbaev, Chairman, L&A Commission
Bokchubaev, E.T., L&C Quality Improvement Expert
Kurmanalieva, T.T., L&C Quality Improvement Expert
Djumabaev, L&C Accreditation Group Leader
Abilov, L&C Quality Improvement Expert
Asamatov, L&C Quality Improvement Expert
Abakirov. L&C Quality Improvement Expert
Isakov, L&C Quality Improvement Expert
Alekseeva, L&C Quality Improvement Expert
Turqunbaeva, L&C Quality Improvement Expert
Tahakeeva, L&C Quality Improvement Expert
Amanalieva, L&C Quality Improvement Expert

D. ACRONYMS

ALOS	Average Length of Stay
CIS	Clinical Information Systems
FGP	Family Group Practice
IDS	Intensive Demonstration Site
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KASSA	Cash-holding agency, Manatory Health Insurance Fund, MHI, BHI
L&A	Licensing and Accredition
MHIF	Mandatory Health Insurance Fund
MIS	Management Information Systems of Medical Information System
MOF	Ministry of Finance
MOH	Ministry of Health
OHD	Oblast Health Department
SOW	Scope of Work
USAID	United States Agency for International Development

X. ANNEXES

A. CONSULTANT SCOPE OF WORK

NAME: George P. Purvis

DATES OF VISIT: June 1-21, 1997

COLLABORATING ZDRAVREFORM MEMBERS: Sheila O'Dougherty

WORK SITES: Bishkek, Kyrgyzstan

TASKS:

1. Monitor the full implementation of the Licensing and Accreditation Process.

2. Finalize implementation of Stage II of the Clinical, MIS for FGPs, including budgeting, accounting, banking, and clinical information systems, management and reporting;

3. Continue training practice managers in FGP financial, accounting, budgeting, banking, and clinical information systems, management and reporting;

4. Continue implementation of the outpatient payment systems including fundholding and the outpatient fee schedule.

5. Conduct workshops as necessary for provider payment systems, management autonomy, and licensing and accreditation.

OUTPUTS:

1. Report summarizing progress on implementation of the L&A process;
2. Recommendations on the development on Stage II and III of the CIS/MIS;
3. Materials for any workshops on Licensing and Accreditation.

B. EXHIBITS

EXHIBIT 1

Licensing and Accreditation Procedure
Decree of Health Care in Kyrgyzstan

The given Decree was developed in accordance with the laws of the Kyrgyz Republic (KR): "Concerning Licensing," "Health Care in Kyrgyz Republic," "Health Insurance in Kyrgyz Republic," with the government Decree "Licensing of Some Types of Activity," and with other legal documents.

Section I. General Regulations

1.1 The given Decree regulates health care licensing and accreditation procedures of health care facilities of the Kyrgyz Republic.

1.2 Health care activities of legal persons, irrespective of their organizational and legal status, type of property, administrative and departmental membership, as well as activities of persons in private practicing, are the subjects of state licensing and accreditation.

1.3 Health care practice license is carried out on equal ground and terms, that meet the requirements set up for these type of licenses. It is forbidden to provide the preference of license issue to state health care facilities, as well as to issue license in order to reduce competition or provide preference to any economic subjects, dependably on property type, membership and location. License for certain type of health care activity must not promote both monopolization of this type of health care and freedom limitation of license agency entrepreneurial activity.

1.4. State health care licensing and accreditation irrespective of the subjects dealing with this care, is carried out by one body—Licensing and Accreditation Commission (LAC)—which has legal status under the Ministry of Health Care.

1.5 Health care licensed by the LAC can be limited to a certain location of Kyrgyzstan Republic or can be applied to the entire Republic of Kyrgyzstan. New licentiate objects are obliged to go though accreditation.

1.6 Foreign legal and natural persons as well as persons without citizenship are licensed on the same terms and in the same order as legal and natural persons of the Kyrgyz Republic, unless otherwise noted in the legislation. Licenses of different countries are recognized in Kyrgyzstan when there are appropriate international agreement

1.7 LAC is running the list of issued, stopped, and canceled licenses and accredited certificates.

1.8 License and accreditation certificate of health care are not transferable to any economic entity or natural person and not to be copied. If the licentiate has to carry out his activity in

several different locations, copies of the license are issued in a typographical manner with stamp and signed by the LAC Chairman.

1.9 License and certificate forms have a protection degree, registration series and number, are issued in a typographical manner and serve as a document of strict reporting. Forms are registered and stored by the LAC.

1.10 To obtain the license and accreditation certificate, legal and natural persons are to provide documents to the LAC in accordance with the list (Appendix 1). Issuance of licenses and accreditation certificates is done on a chargeable basis, only after licentiate provides a document verifying that the license fee, determined according to the LAC service price list, has been paid to the KR budget.

1.11 LAC officials are liable for breaking the rules, procedures or not meeting the requirements of a given Decree in accordance with Kyrgyzstan legislation.

Section II Aims and Objectives

2.1 The purpose of licensing is to evaluate the ability of natural and legal persons to provide health care in accordance with the licensing standards that respond to requirements of having the minimal material and human resource for normal operation of the facility.

2.2 The purpose of accreditation is to evaluate the ability of legal and natural persons to provide high quality service, using available resources, in accordance with accreditation standards.

2.3 The main objectives of licensing and accreditation are:

- improvement of the nation's health via provision of efficient, high quality health care;
- promotion of efficient, high quality health care including upgrading of the skill-level of health care personnel;
- citizen satisfaction with the free choice of high quality physicians and health care facilities and services.

Section III Licensing Procedure

3.1 Health Care Licensing is special permission to provide identified types of care, issued by the state body to health care facilities or private physicians. Health Care Licensing identifies the minimal resources necessary to provide given types of health care (space, equipment, personnel, communications) and verifies the existence of those minimum standards in health care facilities.

3.2 Licensing precedes accreditation, and it is valid for five years. Legal and natural persons must apply for license extension two months in advance of expiration of the existing license.

3.3 A license is an official document that gives a permission for an identified type of health care activity to take place, and defines all the requirements (or terms) of its implementation.

3.4 Licensing has three stages:

1) Documents examination. Authentication of their correspondence to the requirements and terms of activities set up in the legislative documents.
2) Local licensing examination corresponding to the licensing standards and checked by internal and external experts;
3) Decision taking on the granting or denial of a license. At the end of the licensing review, experts provide a detailed report on the health care facility and the decision is made at an LAC meeting.

3.5 The licensing decision is taken within 30 days of all the necessary papers being completed.

3.6 Reasons for license denial are provided in written form within the time required and identified for the licensing issue. Grounds for denial can be:

- missing documents, defined by the list;
- inaccurate information in the documents;
- experts decision that facility does not meet the requirements for a given type of activity;
- missing bill for LAC services.

3.7 If the health care activity takes place in several different locations, copies of the license must point out the location.

3.8 In cases of legal person liquidation or natural person ceasing his activity, the license loses its legal power. In cases of reorganization, name and location change, or the change of identity of a natural person, the license owner is obliged to apply for another registration. Under the next registration the payment is done according to the service scope of LAC

3.9 When deficiencies which caused the denial or revocation of a license are removed, the license can be reinstated. The license is considered reinstated upon decision of the LAC. The LAC is bound to notify the licensee and agencies concerned within three days after taking the decision.

3.10 Every three months the LAC publishes a list of legal entities and persons granted a license for medical activities.

Section IV Accreditation procedures

4.1 Accreditation is identification of standards which promote high quality medical services under current conditions and with available resources and the adequacy of health care facilities to meet those standards. Accreditation is an official recognition of the potential of a health facility to deliver quality care and ranking it to a specific category. It provides higher tariffs for services delivered and promotes the facility's health care personnel to higher qualification categories.

4.2 Primary accreditation is carried out after licensing is valid for a three-year period. Secondary accreditation is carried out every three year after the preceding accreditation. Legal entities and persons must apply to the LAC for secondary accreditation two months before the expiration of the preceding accreditation.

4.3 After the health facility is accredited, it is given an accreditation certificate, a document which guarantees delivery of quality care, provided by legal entity or person.

4.4. Health facilities accreditation includes evaluation of provisional base (territory, building, premises, level of sanitary and maintenance conditions, basic medical equipment, funds, level of resources);
- quality assurance
- personnel potential
- organization and management
- level of service
- sanitary-epidemic status
- occupational safety status/level

4.5 the health facility accreditation process has three stages:

Stage I—pre-accreditation preparation. The facility gets a 2-3 week notice about the on-coming accreditation. Representatives of the health facility get a package of relevant documents from the LAC, including the program and technology of reviewers, accreditation standards, approvals by the Kyrgyz MOH, a list of major documents to be submitted for the review (organization chart of the facility, patients' medical cards, personnel references, financial documentation, quality assurance programs, etc.). After getting these preparation information documents, the facility prepares for the accreditation review, reviews all the documentation, and evaluates adequacy of their performance to the accreditation standards.

Stage II—carrying out accreditation. After confirming the facility's readiness for accreditation, the LAC chairperson in accordance with the type and capacity of the facility determines representation of the expert group which will perform accreditation. At the facility, the expert group examines all departments, evaluates the documentation submitted, and checks up correspondence of the facility to the pre-set accreditation standards. Finally the expert group arranges a final meeting with the facility's administration, at which the preliminary results of the accreditation examination are discussed and recommendations are given.

Stage III—accreditation is decided. The experts present a post-accreditation report with detailed description of the results of the examination of the facility; the LAC meeting takes a final decision on the accreditation of the facility:

a) The facility is accredited (accreditation category and certificate are conferred):
- higher category when the facility meets 90 percent of standard requirements
- first category—70-89 percent
- second category—50-69 percent

b) the facility is accredited provisionally—if it meets 35-49 percent of requirements
c) not accredited—if it meets less than 34 percent or requirements

Qualification categories of the personnel are taken into account.

If the facility applies for the higher category, over 60 percent of the personnel should be in the higher and the first categories; for facilities applying for categories I and II, not less than 40 and 20 percent of personnel respectively should be in those personnel categories.

4.6. In the event the facility is accredited provisionally, it must remove all deficiencies and apply for the secondary accreditation in not less than six months and not more than one year.

4.7 Non-accredited facilities must undergo secondary accreditation after removing deficiencies not less than 18 months and not more than three years after denial of accreditation. After three denials, the facility's license is revoked by the MOH and it is closed.

Section V Rights and obligation of licensed facilities

5.1 The licensed facility enjoys the right:
- to get all the required information and documentation on the procedure and dates of accreditation and licensing;
- to undergo the secondary licensing;
- to undergo the secondary accreditation up to three times in the event of being refused accreditation: in coordination with the LAC change dates of L&A;
- to appeal to the independent medical commission or court in accordance with the effective Law of the KR.

5.2 Obligations:
- to timely submit all the required documents to the LAC to undergo L&A in dates determined;
- to provide valid documentation to the LAC;
- to provide adequate conditions for the L&A experts, reimbursement of trip expenses (hotel, per diem, transportation);
- to submit a receipt to the LAC confirming payment of the L&A fee.

Section VI. Rights and obligations of the licensing body/agency

6.1 Licensing body enjoys the right:

- to contract in accordance with procedures and terms as stipulated by KR Law;
- to use L&A as a tool of coordinating activities of facilities and legal persons, performing medical practice;
- to get all the required information from legal entities and persons for the purpose of L&A of their activities;
- to determine the composition of and regulations for the L&A Commission;
- to direct experts to facilities to carry out the expertise on the site;

- to halt or annul the license validity in accordance with the pre-set order;
- to get all the required information and move proposals to the oblast health departments and Bishkek health department within its authority.

6.2 The Licensing body must submit to the legal persons and entities a list of approved documentation for L&A:
- to perform L&A on a determined date;
- to review types of activities and services applied for L&A in accordance with established standards;
- to perform L&A and take decisions on conferring (or not conferring) the license or certificate not later than within 30 days after the application is submitted;
- to submit information on the results of L&A to the oblast health departments, the Bishkek HD and the Kassa, and professional associations of health workers.

Section VII Financial operation of the Licensing body

7.1 Funds are formed through the moneys generated by delivery of services in accordance with expenses.

7.2 Funds are not subject to the VAT, because the Commission is a not for profit administrative enterprise and does not include marginal profit (profitability) into the costs of services provided.

7.3 The license fee is submitted through a bank transfer of the due sum by the licensee to the republican budget in the amount stipulated by the KR Law.

7.4 Fees for consideration of applications for L&A review, including on-site trips and legal finalizing of licenses and certificates for each legal entity of person, is performed in accordance with the price-list approved annually by the MOH and coordinated with the state department on anti-monopoly policy under the Ministry of Finance. The bill for L&A experts is submitted immediately after determining the date of the review and must be paid before the review. In the event the facility does not pay the bill on time, the L&A review visit is postponed, and the facility must pay a fine in the amount of 10 percent from the cost of L&A of this facility.

7.5 LAC funds are used:

- to pay salaries to the staff, outside experts, and reimbursement of costs;
- to pay taxes and outlays stipulated by the KR Law;
- to pay the labor contract; and
- to provide bonuses to the LAC staff.

7.6 All trip expenses of staff and outside experts are covered by the inviting party.

7.7 Payment from the LAC cash-office is made by cash orders (payment sheets, written requests for cash), signed by the LAC chairperson and head accountant. Expenditures and money transfers should be documented.

7.8 Unused funds in the reporting year are not confiscated

Section VIII. Licensing and accreditation management

8.1 Health care licensing and accreditation management is carried out by LAC with stake holders (MOH departments, Kassa departments and independent health association) through coordination of their activities, legal documentation development, on a self-financed basis of the license and accreditation fee collection

8.2 The LAC creates departments with two experts under the Republican and oblast departments of the MOH. Their main objective will be applications and necessary documents collection and examination, preliminary examination and LAC meetings

8.3 A number of licensing and accreditation issues are to be discussed with other ministries and entities, and local administration

Section IX Licensing and Accreditation control

Licensing and accreditation control of Health care facilities are carried out by correspondent bodies within the authority provided by the Kyrgyzstan Regulation.

List of Documents, necessary for licensing and accreditation procedure:

1. Application for the LAC Chairman's name;
2. Copy of the charter of legal persons and the certificate of state registration, issued by the Ministry of Law of Kyrgyzstan;
3. Copy of the state registration certificate of the local bodies of the National Statistical Committee for natural persons;
4. Copy of the lease agreement or documents, confirming property ownership;
5. Sanitary-Hygienic resolution of the suitability of the premises for the health care activity type;
6. Copy of the State Fair Inspection resolution of the fair protection of the utilized premises;
7. In addition, natural persons have to provide:
    - a copy of their labor record,
    - their diploma of medical education,
    - certificate(s) of upgrading of training or retraining

EXHIBIT 2

LICENSING STANDARDS FOR HEALTH CARE FACILITIES

Licensing standards identify the minimum level of resources absolutely necessary for carrying out health care activities (staff, facility, equipment, communication). The lack of the minimum resources results in license refusal to the health care facility for the applied types of care. The facility should take urgent actions to eliminate non-compliance with the licensing standards.

The following licensing standards must maintained by the health care facility:

I. Administration

II The following management and administration structure of health care facility must be maintained:

⇒ Chief Physician
⇒ Medical Deputy to the Chief Physical
⇒ Financial Deputy to the Chief Physical (An Accountant)
⇒ Logistics Director
⇒ Human Resource Deputy
⇒ Chief Nurse

Large health care facilities should have a full-time staffing schedule. In small hospitals there could be a shared responsibilities in one position.

Conformation of compliance with the standard: provide the organizational chart, staff schedule, and personnel records.

I.2. Management of the HC facility provides:

a) In-time planning

Conformation of compliance with the standard: provide annual work plan of the facility.

b) Personnel manuals, staff requirements are to be defined and met

Conformation of the compliance with the standard: provide personnel manuals and list of employees with their position titles.

c) Development of the necessary papers (job description, written instruction identifying standards of the process)

Confirmation of compliance with the standard: provided job descriptions and written instructions.

d) Internal training on a regular basis and provision of regular upgrading training

Confirmation of compliance with the standard: provide training records, get verbal confirmation of the training with staff, heck the training plan.

e) Management and control of diagnostic, treatment and sanitary and epidemiological operations

Confirmation of compliance with the standard: Interview the administration of the health care facility, check the records of clinical rounds, Medical Consulting Commission resolutions, sanitary control records. Hold the meetings discussing the diagnostic and treatment operation. Health care facility has to provide data, indicating different types of facility activities (inpatient or outpatient) such as: morbidity, frequency of divergence of clinical and pathoanatomical diagnoses, frequency of post-surgical complications, length of stay for hospitalized patients who need surgical intervention, frequency of visiting home visits, sickness and fatality rates, outpatient diagnostics quality rate.

f) Control the effective usage of funds, identify and meet the financial and material needs of health care facility

Confirmation of compliance with the standard: Provide a list of the facility's equipment, medical instruments, medication, transport and data, such as the provision of the population with inpatient care, bed fund usage (annual amount of occupied beds, average continuity of patients stay in a bed).

g) Funding and expenditure control of health care facility

Confirmation of compliance with the standard: Provide all the financial documentation listed in the Appendix 4.

h) Facility premises, communication systems, equipment maintenance and repair control

Confirmation of compliance with the standard: examination of the facility's communication systems and equipment. Provide information about idle (broken) equipment, transport relative weight estimates.

II. STAFF

2.1 Staff level, as noted in the list of staff members, should include no less than 50 percent of certified physicians skilled in modern diagnostics, treatment, and with a set of the necessary skills to provide a qualified care in accordance with the nature of the patient disease

Confirmation of compliance to the standard: Provide a staff schedule, personnel records with copies of diplomas or certificates, list of physicians with their positions, work experience, academic degrees, specialty certificates noted.

2.2 Nursing staff level, as noted in the staff schedule, should include no less than 70 percent of certified nurses, with the necessary skills to provide qualified nursing care in accordance with the nature of the patient disease and be able to carry out doctor's diagnostics and treating orders and prescriptions

Confirmation of compliance to the standard: Provide a staff schedule, personnel records with copies of diplomas or certificates, nurses time-table, list of nurses with their work experience, qualification category, specialty certificate.

III. SANITARY AND EPIDEMIOLOGICAL CONTROL

3.1 Develop and maintain special measures to prevent internal hospital infections and to fight common infectious diseases

Confirmation of compliance to the standard: Provide the plan for prevention of internal hospital infections, infectious disease records, public information record book of sanitary measures. Examination and communication with the staff in order to find out the progress of plan implementation

3.2 Cleanness and correspondent sanitation state of the premises and attached territory

Confirmation of compliance to the standard: Examine sanitation of the premises and attached territory, disposals, toilets; provide sanitation records, and SES inspection records.

3.3. Continuous supply of disinfected water:

Confirmation of compliance to the standard: Verbal interview with the staff and patients, and examination of water supply system.

3.4 Operational sewer

Confirmation of compliance to the standard: Verbal interview with the staff and patients, and examination of sewage system.

3.5 Ventilation system in operational state

Confirmation of compliance to the standard: Verbal interview with the staff and patients, and examination of ventilation system

3.6 Operational heating system in winter and other cold periods

Confirmation of compliance to the standard: Verbal interview with the staff and patients, examination of heating system and fuel storage (in case the heating system is not centralized).

3.7 Constant power supply according to the purpose of the premises (emergency electricity supply in ambulance services)

Confirmation of compliance to the standard: Verbal interview with the staff and patients, and examination of electric and lighting systems.

3.8 Effective sanitary conditions for cooking and food distribution

Confirmation of compliance to the standard: Verbal interview with the staff and patients and kitchen examination.

3.9 Compliance with safety regulations

Confirmation of compliance to the standard: Provide safety records, talk with the staff and patients.

3.10 Facility's (premises and buildings) meeting the requirements of building design standards

Confirmation of compliance to the standard: Provide building design documentation with the architectural bodies resolution, building scheme, examination of the facility.

3. 11. Staff diseases prevention program

Confirmation of compliance to the standard: Provide prevention program, verify presence of medical checks data in the personnel records, talk with personnel.

3.12 Aseptic and antiseptic measures regulations

Confirmation of compliance to the standard: Monitor the measures in the functional departments.

3.13 Laundry, garments and shoes infection

Confirmation of compliance to the standard: Examination of disinfecting equipment, and records of infection and disinfecting measures.

3.14 Sterile medical instruments, equipment, and materials

Confirmation of compliance to the standard: Examination of sterilization equipment examination and sterilization records

3.15 Effective laundering

Confirmation of compliance to the standard: Check for presence of laundry unit or contract with another organization for this type of service. Examination of the washing unit, laundry storage and records.

3.16 Supply of washing and disinfecting powder or liquid

Confirmation of compliance to the standard: Examination of washing and disinfecting powder and liquid storage, talk to people.

3.17 Following the sanitary regulations of food transporting and storage

Confirmation of compliance to the standard: Examination of the vehicles which transport food and of food storage in the facility, talk to people

3.18 Regular sanitary educational work and sanitary training for staff and patients of health care facility

Confirmation of compliance to the standard: Interview staff and patients, check the records.

IV PHYSICAL PLANT, EQUIPMENT AND RESOURCES OF HEALTH CARE FACILITY

4.1 Equipping the health care facility with services and utilities, the presence of vegetation around the perimeter, remoteness from blocks of apartments, highways, railway, airports, convenient access via solid surface pavement, parking for vehicles

Confirmation of compliance to the standard: Visual examination of facility surroundings.

4.2 Presence of rooms for administration and their minimal level of equipment

- Chief Physician office
- Offices for Deputies to Chief physician
- Accounting office
- Human Resource office
- Medical Records room
- Archives

Confirmation of compliance to the standard: Visual examination of rooms and their equipment.

4.3 Equipped premises

- Physician rooms (in outpatient facilities)
- Nurses room
- Logistics—nurse room
- Chief nurse room in each department (in the inpatient facilities)
- Room for technicians

Confirmation of compliance to the standard: Visual examination of rooms and their equipment, check the list of equipment.

4.4 Premises for diagnoses and treatment and their minimal level of equipment

- surgery bed $7m^2$
- therapeutic bed $7m^2$
- pediatric bed 6 m^2
- resuscitation bed $13m^2$
- beds for infants... 3 m^2
- bed for infectious diseases adult patients $8m^2$
- bed for infectious diseases pediatric patients $7m^2$
- treatment room
- dressing room
- operational theater
- delivery department
- sanitary arrangements (toilets, premises for washing and sterilization of bedpans, hot water bags etc.)
- bathroom with a shower
- common rooms for patients (playroom, canteen)

Confirmation of compliance to the standard: Visual examination of premises, equipment, check the list of equipment

4.5 Premises for paraclinical service and their minimal level equipment

- laboratories
- X-ray
- functional diagnoses

Confirmation of compliance to the standard: Visual examination of premises, equipment, check the list of paraclinical rooms equipment

4.6 Equipped insulator

Confirmation of compliance to the standard: Visual examination of insulator check the list of insulator equipment

4.7 Equipped reception department with separate inpatient pediatric and outpatient sections

Confirmation of compliance to the standard: Visual examination of premises, equipment, check the list of equipment

4.8 Physiotherapeutic department with the minimum level of equipment

Confirmation of compliance to the standard: Visual examination of premises, equipment, check the list of equipment

4.9 Pharmacy with the minimum level of equipment

Confirmation of compliance to the standard: Visual examination of premises, equipment, check the list of equipment

4.10 Operating telephone communication

Confirmation of compliance to the standard: Visual examination of the telephone, check the communication

4.11 Operating transport, providing the transporting shipments for health care facility or contract with other organizations

Confirmation of compliance to the standard: Visual examination of available vehicles and documents for this vehicles

NOTE: THESE STANDARDS ARE BEING REVISED.

EXHIBIT 3

AGENDA FOR L&A WORKSHOP
JUNE 11/12 AND 18, 1997
BISHKEK, KYRGYZSTAN

I. INTRODUCTION
- **OBJECTIVES**
- **EXPECTATIONS, WORKSHOP STYLE AND BEHAVIOR**

II. HEALTH CARE REFORM IN THE NEW ENVIRONMENT
- **THE L&A STRATEGIC THINKING PROCESS**
- **ENVIRONMENTAL ASSESSMENT (STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS)**
- **L&A MISSION AND VISION**

III. DIFFERENCES IN WESTERN/CIS HEALTH CARE DELIVERY
- **INTERNATIONAL COMPARISONS**
- **CIS ADVANTAGES/DISADVANTAGES**
- **TRENDS IN HOSPITAL CARE ACCREDITATION**
- **MEDICAL SYSTEMS DESIGN AND HEALTH REFORM**

IV. HEALTH FACILITY "LICENSING" PRINCIPLES
- **HISTORICAL METHODS - PATIENT SAFETY CONCERNS**
- **WHO, HOW, WHEN, AND WHY**
- **ADVANTAGES AND DISADVANTAGES**

V. HEALTH FACILITY "ACCREDITATION" PRINCIPLES
- **HISTORICAL METHODS - HEALTH INSURANCE**
- **WHO, HOW, WHEN, AND WHY**
- **DEVELOPING A ACCREDITATION PROCESS**
- **UTILIZING EXISTING STANDARDS FROM OTHER COUNTRIES**
- **ADVANTAGES/DISADVANTAGES**

VI. KEY ISSUES IN "ACCREDITATION" DEVELOPMENT
- **DATA AND INFORMATION**
- **PRE-SURVEY PLANNING**
- **CARRYING OUT THE SURVEY (INSPECTION) EVALUATION**
- **ROLE PLAYING**
- **SCORING THE EVALUATION**
- **FINAL SURVEY REPORT**
- **PUTTING IT ALL TOGETHER**

DEVELOP WORKPLAN FOR NEXT FEW MONTHS